CHAPTER 9

Home health care services

RECOMMENDATIONS

(The Commission reiterates its March 2011 recommendations on improving the home health payment system. See text box, pp. 232–234.)

CHAPTER 9

Home health care services

Chapter summary

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2013, about 3.5 million Medicare beneficiaries received home health care, and the program spent about $17.9 billion on home health services. The number of agencies participating in Medicare reached 12,613 in 2013.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

***Beneficiaries' access to care*—**Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 97 percent live in a ZIP code with two or more agencies.

- ***Capacity and supply of providers*—**In 2013, the number of agencies continued to increase, with a net gain of 302 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers.
- ***Volume of services*—**In 2013, the volume of services declined slightly. The total number of users increased slightly (0.9 percent), while the average number of episodes per home health user declined by 1.9

In this chapter

percent. This trend is not surprising because spending growth for all health care (including both public and private payers) has slowed in recent years, and Medicare inpatient admissions, an important source of referrals, have declined. These decreases for home health care follow several years of rapid increases: Between 2002 and 2013, the total number of episodes increased by 65 percent, and the number of episodes per home health user increased from 1.6 to 1.9.

***Quality of care*—**Performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking increased slightly in 2013, and the share of beneficiaries reporting improvement in transferring declined slightly in 2013. The share of beneficiaries hospitalized during their home health spell was 27.5 percent, similar to the rate in prior years.

***Providers' access to capital*—**Access to capital is a less important indicator of Medicare payment adequacy for home health care because the service is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, although terms were not as favorable as in prior years. The acquisition of two large home health companies by other health care companies indicates this market is attractive to investors. The significant number of new agencies in 2013 suggests more than adequate capital necessary for start-ups.

***Medicare payments and providers' costs*—**Medicare spending declined by about 0.5 percent to $17.9 billion in 2013, but has increased by 87 percent since 2002. For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies averaged 12.7 percent in 2013 and averaged 17 percent between 2001 and 2013. The Commission estimates that the Medicare margin for 2015 will be 10.3 percent. Two factors have contributed to payments exceeding costs: Fewer visits are delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care.

The Commission reiterates its prior recommendations for home health

The Commission made several recommendations in 2011 to address some issues with the home health payment system and benefit, and we are reiterating these recommendations for the 2016 payment year (Medicare Payment Advisory Commission 2011a). First, the high margins of home health agencies since the start of the prospective payment system (PPS) in 2001 suggest that the payment rates assumed more services than were actually provided. The Commission recommended that the payment rate be rebased to reflect current utilization and

better align Medicare's payments with the actual costs of providing home health services. Second, the Commission recommended that the home health PPS not use the number of therapy visits provided as a payment factor. Trends in utilization and agency profit margins suggest that the financial incentive for therapy use has encouraged providers to favor therapy-intensive episodes. Third, there has been tremendous growth in the use of home health for patients residing in the community, episodes not preceded by a prior hospitalization. The high rates of volume growth for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse, particularly since Medicare does not currently require any cost sharing for home health care. The Commission recommended that Medicare establish a copay for episodes not preceded by a hospitalization to encourage appropriate use of these services. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving service be under the care of a physician. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Unlike most services, Medicare does not require copayments or a deductible for home health services. In 2013, about 3.5 million Medicare beneficiaries received home health care, and the program spent $17.9 billion on home health services. Medicare spending for home health care has doubled since 2001 and currently accounts for about 4 percent of fee-for-service (FFS) spending.

Medicare pays for home health care in 60-day episodes. Payments for an episode are adjusted for patient severity based on patients' clinical and functional characteristics and some of the services they use. If beneficiaries need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. Episodes delivered to beneficiaries in rural areas receive a 3 percent payment increase for 2010 through 2015. Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode. An overview of the home health prospective payment system (PPS) is available at http://www.medpac.gov/documents/payment-basics/home-health-care-services-payment-system-14.pdf?sfvrsn=0.

Use and growth of home health benefit has varied substantially due to changes in coverage and payment policy

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient PPS in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent, and the number of visits more than tripled to about 250 million a year. From 1990 to 1995, spending increased from $3.7 billion to $15.4 billion. As the rates of use and lengths of home health service use increased, there was concern that the benefit was serving more as a long-term care benefit (Government Accountability Office 1996). Further, many of the services provided were believed to be inappropriate or improper. For example, in one analysis of 1995–1996 data, the Office of Inspector General found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, mostly because services did not meet Medicare's standards for a reasonable and necessary service, patients did not meet the homebound coverage requirement, or the medical record did not document that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements of coverage standards, temporary spending caps through an interim payment system (IPS), and replacement of the cost-based payment system with a PPS in 2000.[1] Between 1997 and 2000, the number of beneficiaries using home health services fell by about 1 million, and the number of visits fell by 65 percent (Table 9-1, p. 218). The mix of services changed from predominantly aide services in 1997 to mostly nursing visits in 2000, and therapy visits increased between 1997 and 2013 from 10 percent of visits to 36 percent. Between 1997 and 2000, total spending for home health services declined by 52 percent. The reduction in payments had a swift effect on the supply of agencies, and by 2000, the number of agencies had fallen by 31 percent. However, after this period, the PPS was implemented, and service use and agency supply rebounded at a rapid pace. Between 2001 and 2013, the number of home health episodes rose from 3.9 million to 6.7 million (not shown in table). The number of agencies in 2013 was 12,613, almost 1,700 more agencies than the supply at the 1997 spending peak. Almost all the new agencies since implementation of the PPS have been for-profit providers.

The steep declines in services under the IPS did not appear to have adversely affected the quality of care beneficiaries received; one analysis found that patient satisfaction with home health services was mostly unchanged in this period (McCall et al. 2004, McCall et al. 2003). A study by the Commission also concluded that the quality of care did not decline between the IPS and the implementation of the PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced

TABLE 9–1 **Changes in supply and utilization of home health care, 1997–2013**

				Percent change	
	1997	2000	2013	1997–2000	2000–2013
Agencies	10,917	7,528	12,613	–31%	64%
Total spending (in billions)	$17.7	$8.5	$17.9	–52	111
Users (in millions)	3.6	2.5	3.5	–31	39
Number of visits (in millions)	258.2	90.6	114.1	–65	26
Visit type (percent of total)					
Skilled nursing	41%	49%	53%	20	8
Home health aide	48	31	13	–37	–57
Therapy	10	19	36	101	85
Medical social services	1	1	1	1	–22
Number of visits per user	73	37	33	–49	–11
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.3%	–30	26

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

Source: Home health standard analytical file 2013; *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement 2002.

Budget Act of 1997 led agencies to reduce costs and utilization without a measurable difference in the quality of patient care.

A recent court case between the Department of Health and Human Services and the Center for Medicare Advocacy requires the program to clarify the language in its benefit manual to state that the potential for functional or clinical improvement is not necessary in a covered episode of home health care. Coverage will hinge on existing requirements that the beneficiary needs skilled care and meets the homebound requirement. In 2013, CMS released revised guidance implementing the court settlement. It will be difficult to ascertain the impact of this change until experience is gained under the new standards. However, given the rapid growth the benefit has experienced in the past, it remains possible that utilization could increase.

Patient Protection and Affordable Care Act of 2010 changes to payment for home health services

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs, a process referred to as payment rebasing. The Patient Protection and Affordable Care Act of 2010 (PPACA) includes several reductions intended to address home health care's high Medicare payments, but these policies may not achieve the Commission's goal of making payments more consistent with actual costs.

PPACA calls for the annual rebasing adjustment to be offset by the payment update for each year in 2014 through 2017. CMS set the rebasing reduction to the maximum amount permitted under the PPACA formula, which was equal to 3.5 percent of the 2010 base rate, or an annual reduction of $81 per 60-day episode. However, the size of the base rate has increased since 2010, so this reduction will be less than 3.5 percent and will equal 2.8 to 3.0 percent in each year from 2014 through 2017. In addition, over this period, the payment update will raise payments, resulting in a cumulative net payment reduction of 2 percent (Table 9-2). This modest reduction will likely leave substantial margins for home health agencies (HHAs), which have exceeded 10 percent every year since the implementation of PPS.

PPACA's approach to rebasing also affects low utilization payment adjustment (LUPA) episodes, effectively preventing CMS from raising payments for these services to be equal to cost. The LUPA rate is applied in episodes with fewer than five visits and makes a per visit payment instead

TABLE 9–2 **Impact of PPACA rebasing on payments for 60-day episodes**

	2014	2015	2016	2017	Cumulative change, 2014–2017
Rebasing adjustment	–2.8%	–2.8%	–2.9%	–3.0%	–11.6%
Legislated payment update	2.3	2.2	2.5	2.4	9.6
Net annual payment reduction	–0.6	–0.6	–0.4	–0.4	–2.0*

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Payment update estimates are based on the second-quarter 2014 forecast of the home health market basket. Effects of payment changes are multiplicative.
* Total payment decline would be 4 percent in 2017 if the sequester were in effect.

Source: MedPAC analysis based on data from CMS.

of the case-mix-adjusted 60-day episode payment. CMS's cost analysis found that the LUPA rates were too low by 20 percent to 33 percent. The statutory provisions in PPACA limit the degree to which CMS may change payments; as a consequence, the increase allowed by PPACA covers only a portion of this shortfall. LUPAs are a small share of home health volume, comprising about 9 percent of episodes and 1 percent of payments. However, they play an important role in the payment system because they guard against the incentive to provide more than four visits to receive a higher payment. The incentive to exceed the LUPA threshold is already substantial, with the average LUPA payment equaling $346 compared with $2,859 for the average full episode in 2013. If LUPA rates remain below cost, agencies have even more incentive to provide more than four visits in an episode to qualify for the full episode payment.

PPACA required the Commission to assess the impact of these payment changes for quality of care and beneficiary access (Medicare Payment Advisory Commission 2014a). Empirical data on the effects of rebasing called for by PPACA are not yet available, so the Commission examined the historical relationship between changes in payment and changes in quality and access for the 2001 through 2012 period. Similar to the results presented in this chapter, the volume of episodes grew substantially in this period, even in years that Medicare reduced home health payments. From 2001 through 2010, episode volume for urban, rural, for-profit, and nonprofit providers grew on a per beneficiary basis. These increases in utilization occurred in years in which the average episode payment decreased as well as in years in which the average payment increased, suggesting that the 2 percent payment reduction will not have a negative effect on access.

The Commission examined three quality measures to assess the relationship between past payment reductions and quality, and the results suggest that payment changes during this period did not have a significant effect. During this period, HHAs' overall rate of unexpected hospitalization during the home health episode—an indicator of poor quality—remained steady at about 28 percent, while average payment per episode increased in most years.[2] This finding suggests that hospitalization was not sensitive to changes in payments—that is, the higher payments to HHAs did not lead to fewer hospitalizations. Also during this period, performance on two functional measures of quality—the share of patients demonstrating improvement in walking and the share of patients demonstrating improvement in transferring—generally increased. These increases in quality occurred in years in which the average payment per episode decreased as well as years in which the average payment per episode increased, suggesting that changes in payment have little direct relationship to rates of functional improvement.

The Commission will continue to review access to care and quality as data for additional years become available. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. HHA margins are likely to remain high under the current rebasing policy, and quality of care and beneficiary access to care are unlikely to be negatively affected.

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow policy could result in beneficiaries using other, more expensive

TABLE 9–3

Number of participating home health agencies continues to rise

							Percent change	
	2004	2006	2008	2010	2012	2013	2004–2012	2012–2013
Active agencies	7,651	8,812	9,787	11,453	12,311	12,613	65%	2.5%
Number of agencies per 10,000 FFS beneficiaries	2.1	2.4	2.8	3.2	3.3	3.4	61	2.1

Note: FFS (fee-for-service). "Active agencies" includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Provider of Service file and 2014 annual report of the Boards of Trustees of the Medicare trust funds.

services, while a policy that was too broad could lead to wasteful or ineffective use of home health care (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these broad coverage criteria permit beneficiaries to receive services in the home even though they are capable of leaving home for medical care. Most home health beneficiaries use some form of outpatient services while receiving home health care (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes and face no cost sharing. In addition, the program relies on agencies and physicians to follow program requirements for determining beneficiary needs, but there is some evidence that they do not consistently follow Medicare's standards (Cheh et al. 2007, Office of Inspector General 2001).

Even when enforced, the standards permit a broad range of services. For example, the skilled care requirement mandates that a beneficiary needs therapy or nursing care to be eligible for the home health benefit. The intent of the skilled services requirement is that the home health benefit serves a clear medical purpose and is not an unskilled personal care benefit. However, Medicare's coverage standards do not require that skilled visits comprise the majority of the home health services a patient receives. For about 9 percent of episodes in 2010, most services provided were visits from an unskilled home health aide. These episodes raise questions about whether Medicare's broad standards for coverage are adequate to ensure that skilled care remains the focus of the home health benefit.

In 2010, the Commission made a recommendation to curb wasteful and fraudulent home health services (Medicare Payment Advisory Commission 2010). This recommendation calls on the Secretary to use her authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. PPACA permits Medicare to implement temporary moratoriums on the enrollment of new agencies in areas believed to have a high incidence of fraud. Medicare implemented this moratorium authority for home health agencies in July 2013 in the areas of Miami–Dade, FL; Fort Lauderdale, FL; Houston, TX; Dallas, TX; Chicago, IL; and Detroit, MI. There have also been numerous criminal prosecutions for home health fraud, most notably in Miami and Detroit. However, the Commission still observes many areas with aberrant patterns of utilization. For example, even though Miami has been an area of concentrated effort by CMS and law enforcement agencies, this area still has a utilization rate well in excess of other areas. The persistence of aberrant patterns of utilization suggests that continued, or perhaps even expanded, efforts by all of the enforcement agencies are needed to address the scope of fraud in many areas. In addition, the program may want to fully use the authorities already available. For example, Medicare also has the authority to require HHAs to hold surety bonds, but it has not exercised this authority.[3]

Are Medicare payments adequate in 2015?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2015. We assess beneficiary access to care by examining the supply of home health providers and annual changes in the volume

TABLE 9–4

Fee-for-service home health care services have increased rapidly since 2002

	2002	2006	2010	2012	2013	Percent change 2002–2012	Percent change 2012–2013	Cumulative change, 2002–2013
Home health users (in millions)	2.5	3.0	3.4	3.4	3.5	36.6%	0.9%	37.8%
Share of beneficiaries using home health care	7.2%	8.4%	9.4%	9.2%	9.3%	28.2	0.5	28.9
Episodes (in millions):	4.1	5.5	6.8	6.7	6.7	64.5	–0.5	63.6
Per home health user	1.6	1.8	2.0	2.0	1.9	20.4	–1.4	18.7
Per FFS beneficiary	0.12	0.15	0.19	0.18	0.18	54.4	–0.9	53.0
Payments (in billions)	$9.6	$14.0	$18.4	$18.0	$17.9	88.5	–0.6	87.3
Per home health user	$3,803	$4,606	$5,679	$5,247	$5,169	38.0	–1.5	35.9
Per FFS beneficiary	$274	$387	$540	$484	$479	76.9	–1.0	75.2

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of home health standard analytical file.

of services. The review also examines quality of care, access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by home health care

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2013, almost all beneficiaries (99.4 percent) lived in a ZIP code served by at least one HHA, 97 percent lived in a ZIP code served by two or more HHAs, and over 84 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our review of access from prior years.[4]

Supply of providers: Home health agency supply surpassed previous peak

In 2013, 12,613 HHAs participated in Medicare, a net increase of 302 agencies from the previous year (Table 9-3). Most new agencies in 2013 were for-profit agencies. The number of agencies is now higher than the previous peak in the 1990s when supply exceeded 10,900 agencies. The high rate of growth is a particular concern because many new agencies appear to be concentrated in states that have had a number of significant fraud reports, including California and Texas. These states, like most, do not have state certificate-of-need laws for home health care, which can otherwise limit the entry of new providers.[5]

From 2004—when 99 percent of beneficiaries lived in a ZIP code served by an HHA—to 2013, the number of agencies per 10,000 FFS beneficiaries rose 61 percent, from 2.1 to 3.4 (Table 9-3). Most of the new agencies were for profit. However, supply varies significantly among states. In 2013, Texas averaged 10.5 agencies per 10,000 beneficiaries, while New Jersey averaged less than 1 agency per 10,000 beneficiaries. Some of this variation was likely due to differences in agency size; for example, in New Jersey, the average agency provided 2,909 episodes compared with 354 episodes per agency for Texas. The extreme variation demonstrates that the number of providers is a limited measure of capacity because agencies can vary in size. Also, because home health care is not provided in a medical facility, agencies can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because agencies can use contract staff people to meet their patients' needs.

Growth in episode volume slow after many years of rapid growth

In 2013, the volume of services declined slightly, with the number of episodes declining by 0.5 percent (Table 9-4). The total number of users increased slightly (0.9 percent), while the average number of episodes per home health user declined by 1.4 percent. These decreases follow several years of rapid increases. Between 2002 and 2013, the total number of episodes increased by almost 64

TABLE 9–5

Increase in home health episodes by timing and source of episode

	Number of episodes (in millions)		Cumulative growth	Percent of episodes	
	2001	2012		2001	2012
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.4	76%	20%	21%
Subsequent	1.3	3.1	141	32	45
Subtotal	2.1	4.5	116	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	16%	40	27
Subsequent	0.3	0.5	63	8	7
Subtotal	1.9	2.3	23	47	34
Total	3.9	6.8	72	100	100

Note: PAC (post-acute care). "First" and "subsequent" refer to the timing of an episode relative to other home health episodes. "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including long-term care hospitals), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Some data have been rounded, which may affect subtotals and totals.

Source: CMS Datalink file, 2012.

percent and the episodes per home health user increased from 1.6 to 1.9. Between 2002 and 2013, the share of beneficiaries using home health care increased from 7.2 percent to 9.3 percent.

Total home health use has decreased by 2 percent since 2011, and several factors contributed to this recent decline. Nationwide, spending growth for all health care (including both public and private payers) slowed beginning in 2009, with the rate of increase in economy-wide health care spending near or below the growth rate of the U.S. economy. In addition, certain factors unique to Medicare home health care may have led to the decline in the average number of episodes per 100 beneficiaries in those 2 years. In 2010, the Department of Justice and other enforcement agencies started new investigative efforts to scrutinize home health. In 2011, Medicare implemented a PPACA requirement that physicians conduct a face-to-face examination of a beneficiary before authorizing home health care. Finally, Medicare inpatient hospital discharges, which are an important source of home health care patients, have been declining since 2009 and may account for part of the drop in demand for home health care.

The decline in home health utilization has been concentrated in states with the highest utilization rates: Texas, Louisiana, Oklahoma, Mississippi, and Florida. Volume declined by 11 percent in Texas (more than 115,000 episodes) and by 15 percent in Louisiana. However, these areas experienced substantial growth in the previous 12 years. For example, volume of home health services in Texas increased 289 percent between 2001 and 2013. Even after the recent declines, these 5 states had the highest utilization rates on a per beneficiary basis in 2013; as a group, they averaged 33 episodes per 100 beneficiaries, more than twice the average of all other states. Growth continued in other areas, and 34 states had an increase in volume in 2013. California led this group with an increase of over 30,000 episodes.

Since 2002, home health care stays have grown longer and less focused on post-acute care

Between 2002 and 2013, the average number of episodes per user increased by 19 percent, rising from 1.6 to 1.9 episodes per user (Table 9-4, p. 221). The increase indicates that beneficiaries are receiving home health care for longer periods of time and suggests that home health care serves more as a long-term care benefit for some

beneficiaries. This concern is similar to those in the mid-1990s that led to major program integrity activities and payment reductions. The increase in episodes coincides with Medicare's PPS incentives that encourage additional volume: The unit of payment per episode encourages more service (more episodes per beneficiary), and the PPS makes higher payments for the third and later episodes in a consecutive spell of home health episodes.

The rise in the average number of episodes per beneficiary also coincides with a relative shift away from using home health care as a post-acute care (PAC) service. Over the 2001 to 2012 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 116 percent compared with a 23 percent increase in episodes that were preceded by a hospitalization or PAC stay (Table 9-5). During that period, the share of all episodes not preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent.

The Commission previously examined the characteristics of beneficiaries based on how they most frequently used home health care. Beneficiaries were classified into two categories based on their home health utilization: Beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other post-acute stay were classified as PAC users of home health, while beneficiaries for whom the majority of episodes for 2010 were not preceded by a hospital or PAC stay were classified as community-admitted users.

This cross-sectional analysis suggests that Medicare is serving distinct populations within the home health benefit. In 2010, PAC users averaged 1.4 episodes, while community-admitted users averaged 2.6 episodes. About 42 percent of the episodes provided to community-admitted users were for dual-eligible Medicare and Medicaid beneficiaries; in contrast, the comparable share for PAC users was 24 percent. Community-admitted users also had a larger share of episodes with high numbers of visits from home health aides; for example, aide services were the majority of services provided in 11 percent of the episodes for community-admitted users compared with 4 percent for PAC users. Community-admitted users generally had fewer chronic conditions, tended to be older, and had a higher rate of dementia and Alzheimer's disease. The high share of community-admitted users who were also Medicaid eligible suggests that some of this utilization could have been due to state Medicaid programs inappropriately leveraging the Medicare home health benefit to provide long-term care. Under this practice, states shift the costs of at least some of their long-term care expenses to the Medicare program.

Volume of therapy services is influenced by incentives in Medicare's payment system

The number of therapy visits a beneficiary receives during a home health care episode is one factor that determines Medicare's payment for a home health episode. Generally, providing more therapy visits raises the episode payment. The Commission has long had a concern that allowing utilization to drive payment creates an incentive for agencies to provide more services regardless of clinical need; changes in episode volume generally reflect these incentives. In 2011, the Commission recommended that Medicare redesign the payment system to rely solely on patient characteristics, not on the number of services provided, for setting payment, but CMS has yet to implement this recommendation (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2011a).

CMS has made numerous changes to the case-mix system intended to ensure the proper use of therapy. For example, CMS has introduced additional supervision requirements and adjusted the case-mix weights to reduce the financial incentives to provide more therapy visits.[6] However, even with these changes, the share of episodes qualifying for higher therapy payments has continued to increase over time. Episodes that qualify for additional payment due to therapy visits, those with six or more visits, account for over 90 percent of the increase in episode volume since 2008. Episodes consisting of five or fewer therapy visits increased by 1 percent in 2008 through 2013, while those with six or more therapy visits increased by 26 percent (Table 9-6, p. 224). Since 2011, the number of nontherapy episodes has fallen while the therapy episodes have increased, suggesting that the shift toward therapy may be accelerating.

Poorly targeted rural add-on payment does little to improve access to care

An add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas expires in 2015. The intent of the add-on was to bolster access, but the high level of utilization in many rural areas results in Medicare's per episode add-on being poorly targeted, with most payments made to areas with higher than average utilization. The use of such a broadly targeted add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization

TABLE 9–6

Growth in therapy services has been significant in recent years

	2008	2009	2010	2011	2012	2013	Percent change, 2012–2013	Cumulative change, 2008–2013
Episodes with 5 or fewer therapy visits (in millions)	3.9	4.2	4.2	4.1	4.0	3.9	–3.3%	1.0%
Episodes with 6 or more therapy visits (in millions)	2.2	2.4	2.7	2.7	2.7	2.8	3.4	26.0
Total episodes	6.1	6.6	6.8	6.8	6.7	6.7	–0.5	10.2
Share of episodes qualifying for additional payments based on the amount of therapy provided	36.7%	37.0%	39.3%	39.8%	40.4%	42.0%	N/A	N/A

Note: N/A (not applicable). Annual episode values have been rounded to the nearest hundred thousand, but percent change columns were calculated using unrounded data. The sum of column components may not equal the stated total due to rounding.

Source: MedPAC analysis of home health standard analytical file 2013.

drawing a disproportionate share of the add-on payments. For example, 76 percent of the episodes that received the add-on payments in 2013 were in rural counties with utilization higher than the median utilization for all counties. In contrast, the rural counties below the median accounted for 23 percent of the episodes eligible for the add-on payment. Rural counties with the lowest utilization per beneficiary, those in the bottom fifth of utilization, accounted for less than 4 percent of the episodes eligible for the rural add-on payment. Relatively few of the add-on payments were made to areas with low utilization.

In its June 2012 report to the Congress, the Commission noted that Medicare should target rural payment adjustments to those areas that have access challenges (Medicare Payment Advisory Commission 2012a). The large share of payments made to rural areas with above-average utilization does nothing to improve access to care in those areas and raises payments in markets that appear to be more than adequately served by HHAs. Some of the counties with aberrant patterns of utilization suggestive of fraud and abuse are rural; for example, 21 of the 25 top-spending counties in 2013 are rural areas (Table 9-7). Higher payments in areas without access problems can encourage the entry or expanded operations of agencies that seek to exploit Medicare's financial incentives. More targeted approaches that limit rural add-on payments to areas with access problems should be pursued.

The counties listed in Table 9-7 have the highest utilization rates, but high utilization is not confined solely to these areas. Counties in the top quintile have an average utilization of 31 episodes per 100 beneficiaries, 70 percent higher than the national average. These counties include 194 urban counties and 446 rural counties, indicating that high utilization is prevalent in both geographic categories (80 percent of the Medicare beneficiaries residing in the top-quintile counties reside in urban counties). In 2013, a county at the 75th percentile used 17 episodes per 100 beneficiaries, while a county at the 25th percentile used 8 episodes per 100 beneficiaries. In MedPAC's review of geographic variation in Medicare spending, post-acute care services had the greatest variation in spending among areas, and variation in home health services contributed to the wide spread of spending (Medicare Payment Advisory Commission 2011b). This wide distribution suggests that reducing use and spending in many high-spending areas, beyond those listed on Table 9-7, could lower program costs.

Quality of care: Quality measures generally held steady or improved

Medicare reports several quality measures on its Home Health Compare website from which we obtained recent trends for measures associated with function and hospitalization (Table 9-8). In general, the share of beneficiaries showing improvement on the functional

TABLE 9–7 **Most counties with the highest rates of beneficiaries using home health in 2013 were rural**

State	County	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval*	36.4%	4.4	158.8
TX	Brooks*	34.0	3.9	132.5
FL	Miami–Dade	28.9	2.5	72.2
TX	Jim Hogg*	27.8	4.3	120.7
TX	Willacy*	27.0	3.8	103.9
TX	Jim Wells*	26.3	4.1	106.6
LA	East Carroll*	25.7	3.9	100.9
OK	Choctaw*	25.7	4.0	102.7
TX	Zapata*	25.7	4.1	106.1
TX	Starr*	25.6	3.9	98.9
MS	Claiborne*	23.2	2.8	65.1
TX	Webb	23.0	3.9	89.9
LA	Madison*	22.3	4.3	95.5
TX	Collingsworth*	21.9	4.4	95.6
TN	Hancock*	21.8	2.9	63.5
MS	Holmes*	21.4	3.0	64.8
OK	McCurtain*	21.1	4.1	87.3
TX	Throckmorton*	20.9	4.3	89.0
TX	Hidalgo	20.8	3.5	73.6
OK	Greer*	20.4	3.3	66.8
OK	Latimer*	20.1	4.1	82.9
TX	Robertson	20.1	3.4	67.7
TX	Falls*	20.1	3.5	71.0
MS	Yazoo*	19.9	3.2	63.1
OK	Coal*	19.8	3.2	64.0

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded.
*Rural county.

Source: MedPAC analysis of the 2013 home health standard analytical file and the 2013 Medicare denominator file.

TABLE 9–8 **Average home health agency performance on select quality measures**

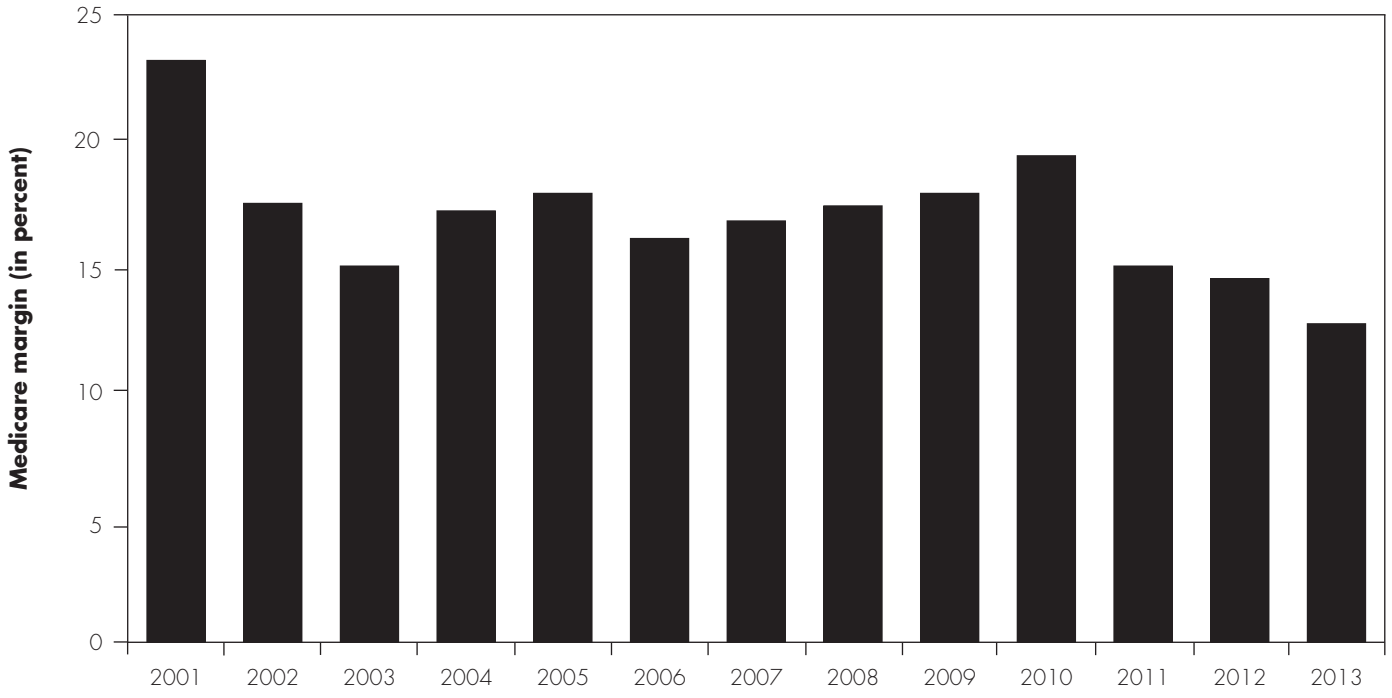
	2003	2006	2010	2012	2013
Share of an agency's beneficiaries with improvement in:					
Walking	34.8%	41.2%	53.5%	58.3%	58.5%
Transferring	49.1	52.7	52.7	54.6	53.8
Hospitalization	27.5	28.1	28.4	27.5	N/A

Note: N/A (not available). Data are risk adjusted for differences in patient condition among home health patients; includes fee-for-service beneficiaries only. The measures for walking and transferring changed in 2011 and are not comparable to data from prior years.

Source: MedPAC analysis of data provided by the University of Colorado.

FIGURE 9–1

Medicare margins of freestanding home health agencies since 2001



Note: An audit of 2011 cost reports indicated that home health agencies overstated their costs that year by 8 percent.

Source: Medicare cost reports 2013.

measures has increased since 2003. The rate of hospitalization has not changed significantly. In 2013, the share of patients with improvement in walking increased slightly, while the share of patients with improvement in transferring declined slightly. These data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that the beneficiaries included in the measure are probably healthier and more likely to have positive outcomes.

As the Commission has noted in the past, there was variation in performance on these quality measures among home health agencies. For example, in 2012, the rate of hospitalization for an agency at the 25th percentile was 20 percent compared with 41 percent for an agency at the 75th percentile. Nonprofit agencies had a lower rate of hospitalization than for-profit agencies, and facility-based agencies generally had a slightly lower rate than freestanding agencies.

The variation in agency performance suggests an opportunity for quality improvement. The Commission recommended that the Congress direct the Secretary to establish a payment incentive that would reduce payments for agencies with relatively high rates of rehospitalization (Medicare Payment Advisory Commission 2014b). This action would align HHA incentives with those of hospitals under the Hospital Readmissions Reduction Program. Such a policy would also recognize home health care's unique role as a provider that facilitates the transition from inpatient settings to the community. Hospitals may be unable to reduce avoidable readmissions without assistance from home health care, and HHAs would be better partners if they were subject to the same financial incentives.

Providers' access to capital: Access to capital for expansion is adequate

Few HHAs access capital through publicly traded shares or through public debt such as issuing bonds. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital

markets. Information on publicly traded home health care companies provides some insight into access to capital, but has its limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of agencies in the industry. For these reasons, access to capital is a smaller consideration for home health than for other health care sectors receiving Medicare payment.

Analysis of for-profit companies indicates that they had adequate access to capital in 2013. While the large publicly traded home health firms sold or closed some agencies in 2013, there was also major investment to expand operations. For example, Gentiva purchased Harden Home Health Care, and Almost Family purchased two regional chains to significantly expand its size in 2013. In 2014, two large home health chains were acquired by firms that primarily operate other post-acute services. Kindred Healthcare reached an agreement to purchase Gentiva, one of the two largest publicly traded home health firms, in the fall of 2014. The HealthSouth Corporation, which operates inpatient rehabilitation facilities, recently announced a $750 million purchase of Encompass, which operates home health agencies in several states. Interest by investors and the continued increase in agency supply suggest that access to capital remains adequate for entities that seek to invest in home health care.

Medicare payments and providers' costs: Payments decreased in 2013 while cost growth remained low

In 2013, average Medicare payments per episode declined by about 0.2 percent, a result of several policies intended to address changes in coding practices unrelated to patient severity and to reduce Medicare's historically high payments for this service. Total spending declined by 0.6 percent to $17.9 billion. However, this decline is modest compared with the growth the home health benefit has experienced in prior years; since 2002, spending has increased by over 80 percent.

The average cost per episode in 2013 increased by about 0.7 percent relative to the prior year. Low or no cost growth has been typical for home health care, and in some years we have observed a decline in cost per episode (in 2012 the cost per episode declined by 1.3 percent). The ability of HHAs to keep costs low has contributed to their high margins under the Medicare PPS.

Medicare margins have been high since 2001

Home health margins for freestanding HHAs have been very high since the PPS was implemented; Medicare margins averaged 17 percent between 2001 and 2013 (Figure 9-1). These high margins likely have encouraged the entry of new HHAs; the number of new agencies in 2013 was higher than the previous year, and the total number of agencies participating in Medicare has increased by an average of about 509 agencies a year since 2003. The high overpayments have led the Commission to recommend that home health rates be lowered to a level consistent with costs (Medicare Payment Advisory Commission 2011a).

The average margin may be even higher than these amounts for many agencies. The margins that the Commission reports rely on the cost and payment information provided by HHAs on the Medicare cost report. CMS stopped routinely auditing these cost reports when the PPS was implemented in 2001, but it recently conducted an audit of 100 HHA cost reports for 2011. The audit found that costs were overstated by an average of 8 percent in 2011. Because costs were overstated, the profit margin of 15 percent for 2011 was likely understated, and actual margins could have been significantly higher. If reported costs in earlier years were also overstated, then the margins for 2010 and earlier could also be significantly higher. However, audited cost reports are not available for this period, and it is difficult to determine how the degree of misstatement in costs and payments may have changed over this time.

Medicare margins in 2013 declined slightly

In 2013, HHA margins in aggregate were 12.7 percent for freestanding agencies (Table 9-9, p. 228). Financial performance varied from –3.4 percent for an agency at the 25th percentile of the margin distribution to 22 percent for an agency at the 75th percentile (data not shown). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. These margin analyses include the effects of the sequester that entered into effect in 2013.

The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies function in the financial context of hospital operations. Margins for hospital-based agencies in 2013 were –15.5 percent. The lower margins of hospital-based agencies are chiefly due to their higher costs, some of which may be due to overhead costs allocated to the

TABLE 9–9 **Medicare margins for freestanding home health agencies, 2012 and 2013**

	2012	2013	Percent of agencies, 2013	Percent of episodes, 2013
All	14.5%	12.7%	100%	100%
Geography				
Majority urban	14.9	13.1	84	83
Majority rural	12.8	11.0	16	17
Type of ownership				
For profit	15.3	13.7	89	79
Nonprofit	14.5	10.0	11	21
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	7.1	6.1	20	3
Second	8.1	7.8	20	6
Third	10.1	8.9	20	11
Fourth	13.2	11.2	20	19
Fifth (largest)	16.8	14.8	20	61

Note: N/A (not available). Agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of Home Health Cost Report files from CMS.

HHA from its parent hospital. The lower inpatient costs due to shorter hospital stays may more than compensate for any losses from operating an HHA. Urban agencies had slightly higher rates than rural agencies, and larger agencies generally had higher margins than smaller agencies.

Relatively efficient HHAs serve patients with attributes similar to all other HHAs' patients

The Medicare Modernization Act of 2003 requires that the Commission consider the financial performance of an efficient provider in its review of payment adequacy. We examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrates better performance on these metrics relative to its peers (Table 9-10). The measure of cost is risk adjusted per episode, and the measure of quality is a risk-adjusted measure of hospitalization. (The hospitalization measure refers to a hospital stay that occurs during or after a home health episode of care.) Our approach categorizes an HHA as relatively efficient if the agency was in the lowest third on at least one measure (either low cost per episode or a low hospitalization rate) and was not in the highest third of the other measures for three consecutive years (2009 to 2011). About 17 percent of agencies met these criteria in this period. Note that there is one difference in our methodology relative to previous years (we do not exclude high-use areas).

Relatively efficient agencies had margins that were 5.5 percentage points higher with a hospitalization rate that was more than 20 percent lower than other HHAs, and the average cost per visit was about 12 percent lower compared with other HHAs. Relatively efficient HHAs provided services for more episodes, but about 1.2 fewer visits per episode than other HHAs. There was generally no significant difference between the patient attributes of relatively efficient providers and other agencies since they served similar shares of rural and dual-eligible beneficiaries. Compared with other regions, the Middle Atlantic, South Atlantic, and West North Central regions had greater shares of relatively efficient providers.

The most recent Commissioner discussions of the efficient provider analysis raised several questions about the existing methods for defining efficient providers and generated new ideas for consideration. The Commission staff will be undertaking a re-examination of the efficient provider analysis.

TABLE 9–10

Performance of relatively efficient home health agencies

Provider characteristics	All	Relatively efficient provider	All other providers
Number of agencies	4,280	711	3,569
Share of for-profit agencies	83%	76%	84%
Medicare margin			
2012	14.5%	19.0%	13.5%
2011	15.2%	21.1%	14.0%
Quality			
Hospitalization rate (2011)	28%	23%	29%
Costs and payments			
Cost per visit, standardized for wages (2012)	$130	$126	$144
Average payment per episode (2012)	$2,662	$2,552	$2,687
Patient severity case-mix index	0.99	1.02	0.99
Visits per episode			
Total visits per episode (2012)	16.7	15.7	16.9
Share of visits by type			
Skilled nursing visits	51%	52%	51%
Aide visits	13%	10%	14%
MSS visits	1%	1%	1%
Therapy visits	35%	37%	34%
Size, 2012 (number of 60-day payment episodes)			
Median	930	1,012	931
Mean	529	622	513
Share of episodes, 2012			
Low-use episode	9%	10%	8%
Outlier episode	2%	2%	2%
Community-admitted episodes	66%	60%	68%
Therapy episodes	37%	37%	36%
Beneficiary demographics, 2012			
Share of episodes provided to dual-eligible Medicare/Medicaid beneficiaries	34%	32%	35%
Average age	77	77	77
Share of episodes provided to rural beneficiaries	22%	22%	22%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2009–2011). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using a risk-adjusted cost per episode. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that received a very high number of visits and qualified for outlier payments. Community-admitted episodes are those episodes that were preceded by a hospitalization or prior post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and standard analytic file.

TABLE 9–11 **Medicare visits per episode before and after implementation of PPS**

Type of visit	Visits per episode			Percent change in:	
	1998	2001	2013	1998–2001	2001–2013
Skilled nursing	14.1	10.5	9.4	–25%	–10%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	6.4	39	23
Home health aide	13.4	5.5	2.4	–59	–57
Medical social services	0.3	0.2	0.1	–36	–32
Total	31.6	21.4	18.3	–32	–15
Visits per episode for fully prospective episodes (excludes outlier episodes and episodes with 6 or more therapy visits)	N/A	16.2	11.9	N/A	–27

Note: PPS (prospective payment system), N/A (not applicable). The PPS was implemented in October 2000. Data exclude low-utilization episodes.

Source: Home health standard analytic file.

Medicare margins remain high in 2015

In modeling 2015 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2013, and the year for which we are making margin predictions, 2015. The major changes are:

- –0.6 percent payment change in 2014, the net impact of a positive payment update (2.3 percent) and the rebasing reduction of $80.95 per episode;
- –0.6 percent payment change in 2015, the net impact of a positive payment update (2.3 percent) and the $80.95 per episode rebasing reduction;
- 3 percent add-on in effect for episodes provided in rural areas in 2014 and 2015; and
- assumed episode cost growth of 0.8 percent per year for 2014 and 2015 and annual nominal case-mix growth of 0.5 percent.

On the basis of these policies and assumptions, the Commission projects a margin of 10.3 percent in 2015. This projection assumes that the sequester reduction of 2 percent that went into effect in 2013 remains in effect through 2015. If the sequester does not continue, margins would be about 2 percentage points higher in 2015.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first year of the PPS, average margins equaled 23 percent. The high margins in the first year suggest that the PPS established a base rate well in excess of costs. The base rate assumed that the average number of visits per episode would decline about 15 percent between 1998 and 2001, while the actual decline was about 32 percent (Table 9-11). By providing fewer visits than anticipated, HHAs were able to garner extremely high average payments relative to the services provided.

However, these trends are distorted by the incentives in the payment system and may understate the home health industry's ability to control costs. Recall that the PPS rewards additional therapy visits with higher payments for each visit and has a similar per visit payment increase for outlier episodes. The average number of visits per episode has declined by 27 percent since 2001 for episodes that were paid on a fully prospective basis (that is, ineligible for higher payment based on the number of visits provided), a decline in visits that was almost double the average for all episode types. The decline in visits for episodes paid on a strictly prospective basis may best represent the efficiencies agencies can achieve when the payment system does not reward additional services.

The declining number of visits per episode has contributed to higher agency margins. This mismatch between payment levels and cost growth led to the Commission recommending in March 2010 that Medicare rebase payments to be closer to costs (Medicare Payment Advisory Commission 2010). PPACA mandated reductions beginning in 2014, but these reductions leave HHAs with margins well in excess of costs. Overpaying for home health care has negative financial consequences for the federal budget and the beneficiary; implementing the Commission's prior recommendation for rebasing would better align Medicare's payments with HHAs' actual costs.

How should Medicare payments change in 2016?

A review of the Commission's indicators suggests that access is more than adequate in most areas and that aggregate Medicare payments are well in excess of costs. These indicators are similar to our findings in previous years, and for these reasons, the Commission is reiterating its recommendations from March 2011 (see text box, pp. 232–234) as its position with respect to the 2016 payment update. The Commission has recommended a number of changes to lower payments, address vulnerabilities in the payment system, and establish a new incentive to encourage efficient use of the benefit. ■

The Commission reiterates its March 2011 recommendations on the home health care benefit

In 2011, the Commission noted several problems with the Medicare home health care benefit and made several recommendations to reduce fraud, improve provider and beneficiary incentives, and eliminate the high overpayments under the home health care prospective payment system. We offered four recommendations to address these problems. Those recommendations are included here with updated commentary and rationales.

Recommendation 8-1, March 2011 report

The Secretary, with the Office of Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud.

The Patient Protection and Affordable Care Act of 2010 (PPACA) expanded Medicare's authority to stop payment for fraudulent or suspect services, and last year, the Commission recommended that the Secretary exercise this new authority to curb fraud in home health care. For many years, the Commission has published a list of counties with questionable utilization patterns (Table 9-7, p. 225). As the Commission recommended in the 2011 March report, these counties would be appropriate areas for the Secretary to exercise new PPACA authorities for investigating and interdicting home health fraud. The Department of Health and Human Services began exercising some of these authorities in 2013 when it announced a moratorium on the enrollment of new agencies in several areas of the country.

Medicare and the law enforcement community have made some progress in closing questionable agencies. However, the continued high utilization in many areas, including areas that have experienced significant law enforcement activity, suggests that expanded efforts are warranted. These efforts could include expanded enforcement activity or use of the program's administrative authority. For example, PPACA permits Medicare to suspend payments if CMS, in consultation with the Office of Inspector General (OIG), finds credible evidence of provider fraud, though CMS has yet to use the authority despite the noted aberrant patterns of home health utilization. Medicare and the other enforcement entities should continue to review home health care spending and pursue providers that appear to engage in behavior that is potentially fraudulent or wasteful.

Implications 8-1

Spending

- The Congressional Budget Office has scored savings from the PPACA provision, so its baseline assumes savings based on the new authority. Implementing this authority would lower home health spending if fraud were discovered. CMS and OIG would incur some administrative expenses.

Beneficiary and provider

- Appropriately targeted reviews would not affect beneficiary access to care or provider willingness to serve beneficiaries.

Recommendation 8-2, March 2011 report

The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket update for 2012.

Medicare has overpaid for home health since establishment of the prospective payment system (PPS) in 2000. The higher payments create financial incentives that can encourage providers to deliver services even when they are unnecessary or of low value. Although PPACA has implemented some payment reductions, they are offset by the annual payment update (Table 9-2, p. 219).

Our recommendation would reduce payments by more than the current law rebasing. First, our policy would not apply the annual payment update as an offset to the rebasing reduction. Second, we would increase the payment reduction to reflect the finding that home health agencies (HHAs) overstated the costs of providing Medicare services on their cost reports. Finally, the payments could further be lowered to account for the lower costs of relatively efficient providers. As noted in Table 9-10 (p. 229), these providers typically have margins that are

(continued next page)

The Commission reiterates its March 2011 recommendations on the home health care benefit (cont.)

about 5 percentage points higher than the overall average. In addition, the Commission believes that its recommendation to eliminate the use of therapy thresholds in the PPS should be implemented along with rebasing. This change would ensure that providers do not attempt to offset rebasing with higher payments by increasing the number of therapy visits they provide.

The Commission expects that rebasing may cause some HHAs to leave the Medicare program, but this effect may be offset by the entry of new providers. The barriers to entry in home health care are lower than for other Medicare providers. Home health care does not require extensive capital expenditures like facility-based providers do, and many states do not require certificate-of-need analysis to establish a new home health agency.

Implications 8-2

Spending

- This recommendation would reduce spending for Medicare services by $250 to $750 billion in 2016 and $5 to $10 billion over five years.

Beneficiary and provider

- Some reduction in provider supply is likely, particularly in areas that have experienced rapid growth in the number of providers. Access to appropriate care is likely to remain adequate, even if the supply of agencies declines.

Recommendation 8-3, March 2011 report

The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and nontherapy services and should no longer use the number of therapy visits as a payment factor.

The Commission is concerned that Medicare's home health PPS encourages providers to base therapy regimens on financial incentives and not patient characteristics. The PPS uses the number of therapy visits provided in an episode as a payment factor: the more visits a provider delivers, the higher the payment. The higher payments obtained by meeting the visit thresholds have led providers to favor patients who need therapy over patients who do not and have encouraged providers to deliver services that are of marginal value. The Commission's recommendation would use patient characteristics to set payment for therapy, the same approach Medicare currently uses for setting payment for all other services covered in the home health PPS.

Implications 8-3

Spending

- The payment policy changes are designed to be implemented in a budget-neutral manner and should not have an overall impact on spending.

Beneficiary and provider

- Patients who need therapy may see some decline in access, but these services would be available on an outpatient basis after the home health episode ended.

Recommendation 8-4, March 2011 report

The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use.

The health services literature has generally found that beneficiaries consume more services when cost sharing is limited or nonexistent, and some evidence suggests that the additional services do not always contribute to better health. The lack of cost sharing is a particular concern for home health care because PPS pays for care on a per episode basis that rewards additional volume. The lack of a cost-sharing requirement stands in contrast to most other Medicare services, which generally require the beneficiary to bear some of the costs of Medicare services.

One concern with cost sharing is that it can lead beneficiaries to reduce their use of effective as well as ineffective care. Although some studies have found evidence of adverse effects of reduced care due to cost sharing (Chandra et al. 2010, Rice and Matsuoka 2004), the RAND health insurance experiment concluded that, on average, nonelderly patients who consumed less health care because of cost sharing suffered no net

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The Commission reiterates its March 2011 recommendations on the home health care benefit (cont.)

adverse effects (Newhouse 1993). The Commission's review of the impact of medigap insurance generally found that beneficiaries with this insurance had higher total Medicare spending (Medicare Payment Advisory Commission 2009). The results of the RAND health insurance experiment and the Commission's study suggest that a home health care copay would decrease use of home health care and result in lower overall Medicare spending.

To encourage appropriate use, the Commission recommended that Medicare add an episode copayment for services not preceded by a hospitalization or other post-acute service.[7] The high rates of volume growth for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse. The addition of a copayment would allow beneficiary cost consciousness to counterbalance the broad nature of the benefit's use criteria and the volume-rewarding aspects of Medicare's per episode payment policies.

Implications 8-4

Spending

- A copay of $150 per episode (excluding low-use and posthospital episodes) would reduce spending for Medicare services by $250 to $750 billion in 2016 and $1 to $5 billion over five years.

Beneficiary and provider

- Some beneficiaries might seek services through outpatient or ambulatory care for which Medicare already has cost-sharing requirements. Some beneficiaries who need relatively few services would have lower cost sharing if they substituted ambulatory care for home health care. ■

Endnotes

1 The Balanced Budget Act of 1997 ended coverage of home health care for the purpose of venipuncture services alone.

2 The rate excludes hospitalizations that were not planned in advance or part of a normal course of treatment (for instance, organ transplant).

3 Surety bond firms review the organizational and financial integrity of an HHA and agree to cover the Medicare obligations, up to a set amount, for those agencies that the surety bond firm believes are low risk. A surety bond would cover liabilities that occur when an agency does not repay funds it owes Medicare (for example, when an agency is found to have improperly billed for services) (Government Accountability Office 1999).

4 As of November 2014, our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes where an agency has provided services in the past 12 months. This definition may overestimate access because agencies need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.

5 Certificate-of-need laws vary from state to state, and not all states have them. In general, the laws require that an area have a demonstrated need for additional health care services before a new provider is permitted to enter the market.

6 In 2012, CMS reduced payments for episodes with 20 or more therapy visits by 5 percent and reduced payments for episodes with 13 to 19 visits by 2.5 percent. Payments for episodes with five or fewer therapy visits were increased by 3.75 percent. The net effect of the adjustment was budget neutral.

7 The recommendation applied only to full episodes—those that included five or more visits.

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